Re: Deceased Patient Medical Records Requests

To obtain a deceased patient’s medical records, you will need:

1. Executor of the Estate Proof
   a. If this does not exist, the attached affidavit must be completed and notarized with a copy of the death certificate.
2. And a completed Authorization to Release Medical Information form.

Submit the above documents to Medical Information Management either in person or via mail:

MIM Operations
110 Doan Hall
410 W 10th Avenue
Columbus, Ohio, 43210

Questions, please call (614) 293-8657.

Regards,

Release of information
Medical Information Management, Operations
Affidavit for Release of Medical Records

Patient Name: ____________________________
Date of Birth: ____________________________
SSN: ____________________________
Deceased Date: ____________________________

Today’s Date: ____________________

Dear Ohio State University Wexner Medical Center:

I am requesting copies of medical records and am providing the following information to comply with your request:

• There are no other relatives that are rightful heirs to the information.
• No estate exists and I have attempted but was unable to obtain a release from probate court.
• I will provide picture identification upon request and at the time of delivery.

Sincerely,

________________________________  ________________________________
Name of Requestor    Relationship to Decedent

Sworn to and subscribed in my presence this _________ day of ______________, 20___.

________________________________
Notary Public
<table>
<thead>
<tr>
<th>Patient Name (First, Middle, Last)</th>
<th>Date of Birth: <strong>/</strong>/__</th>
<th>Last 4 digits of Patient's Social Security Number:</th>
<th>Telephone Number: (_ _ _)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient's Address</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dates of Service to Release (From): __________ (To): __________</td>
<td></td>
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<tr>
<td>Specific Reports to be Disclosed:</td>
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<tr>
<td>☐ Emergency Department Records</td>
<td>☐ Progress Notes</td>
<td>☐ Laboratory Reports</td>
<td></td>
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<tr>
<td>☐ Discharge Information</td>
<td>☐ Therapy Notes</td>
<td>☐ Pathology Reports</td>
<td></td>
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<tr>
<td>☐ History and Physical Exam</td>
<td>☐ Plan of Care</td>
<td>☐ Radiology Reports</td>
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<tr>
<td>☐ Consults/Assessment</td>
<td>☐ Operative/Procedure Reports</td>
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<td></td>
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<tr>
<td>☐ Other:</td>
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<tr>
<td>Purpose of Disclosure: ☐ Medical Treatment ☐ Disability ☐ Insurance ☐ Legal Reasons ☐ Personal ☐ Other:</td>
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<tr>
<td>Release Information From:</td>
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<tr>
<td>☐ James Cancer Hospital and Solove Research Institute</td>
<td>☐ Ohio State University Wexner Medical Center</td>
<td>☐ East Hospital</td>
<td>☐ Ross Heart Hospital</td>
</tr>
<tr>
<td></td>
<td>☐ Brain and Spine Hospital</td>
<td>☐ OSU Harding</td>
<td>☐ University Hospital</td>
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<td>☐ Dodd Hall</td>
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<tr>
<td>Release Information To: ☐ Other (specify recipient and complete address below)</td>
<td>Release Information To: ☐ The Ohio State University Wexner Medical Center (specify provider) ☐ James Cancer Hospital and Solove Research Institute (specify provider)</td>
<td></td>
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<tr>
<td>(Name)</td>
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<tr>
<td>(Address)</td>
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<td>(Phone)</td>
<td>(Fax)</td>
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<tr>
<td>(Patient's email)</td>
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</table>

Based on regulatory requirements, a fee may be charged for copies of medical records. If you have questions about an invoice you have received, please contact CIOX Health at 1-800-367-1500. CIOX Health is a business associate of The Ohio State University Wexner Medical Center and James Cancer Hospital and Solove Research Institute.

I give the facility as indicated above and its employees and business associates, CIOX, permission to release my medical record, or parts of my record, as noted above and as defined in the designated record set. I understand that the information released may include treatment for physical and mental illness, alcohol or drug use, AIDS (Acquired Immunodeficiency Syndrome) or HIV testing. I know I need to sign a separate form to release any notes related to psychotherapy. This form is valid for one year unless I give written notice prior to the release of the information, as stated in the Notice of Privacy Practices.

The information released as a result of this form may be re-disclosed by the recipient and may no longer be protected by federal or state privacy rules, such as HIPAA.

I understand that treatment or payment for the care I have received at OSUWMC is not dependent on my signing this release, unless treatment is for research or the care was given to provide information to a third party.

If I am requesting records related to substance use disorder, federal law prohibits further release of my information without my written consent and requires an additional specific form to be completed before the records are provided.

Signature of the Patient or Person Authorized to Consent: __________________________ Date Signed: __________

Relationship if not the Patient: __________________________ Date Signed: __________

Witness (optional): __________________________ Date Signed: __________

Submit requests to one of the following:
- The Ohio State University Wexner Medical Center
  Medical Information Management
  110 Doan Hall, 410 West 10th Avenue
  Columbus, Ohio 43210-1228
  Phone: (614) 293-8657
- East Hospital
  Medical Information Management W113
  181 Taylor Avenue
  Columbus, Ohio 43203 - 1779
  Phone: (614) 257-2544
- The James Cancer Hospital and Solove Research Institute
  1st Floor James Cancer Hospital
  James A061
  460 West 10th Ave
  Columbus, OH 43210 - 2500
  Phone: (614) 293-8657

☐ THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER
☐ JAMES CANCER HOSPITAL AND SOLOVE RESEARCH INSTITUTE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: __________________________
Medical Record Number: __________________________
Date of Birth: __________________________

MC040184 (11/19)